Please fill out this form thoroughly.

Name:( )
Nationality:( )
Sex: Male( ) Female( )
Age:( )
Date of Birth: (year /month /day)
Present Address:

Business Address:

Phone number:

1. What is the problem?

2. Are you allergic to medication?

3. Which diseases undermentioned have you ever had?
Please put a mark on parentheses and fill in.

– Asthma( ), Heart disease( ), Glaucoma( ), Thyroid disease( ),
Diabetes mellitus( ), Prostate gland( ), Gastric or duodenal ulcer( ),
Gall stone( ), Kidney stone( ), Sinusitis( ), Otitis media( ),
The others( )

Surgery: Appendectomy ( ), Caesarean operation( ), Hysterectomy( ),
other surgeries( )

).

4. Do you have any medicines which a doctor has prescribed for you?
– Yes( ), No( )
If 'Yes', please write them down.
( )

5. (To female) Are you pregnant now?
– Yes( ), No( )